

Health Insurance Portability and Accountability Act (HIPAA) Authorization to Release Medical Information

A. STUDENT/PATIENT INFORMATION

Student Name (Last, First, Middle): _____

Date of Birth: _____ Sex: M F Permanent Student ID #: _____

B. INFORMATION TO BE RELEASED FROM (√ as needed):

- _____ School District
- Healthcare Provider/Clinic/Other: _____
Phone number: _____ Medical Record #: _____
- Healthcare Provider/Clinic/Other: _____
Phone number: _____ Medical Record #: _____

- ___ Endocrinology
- ___ Gastroenterology
- ___ Neurology
- ___ PT/OT
- ___ Pediatrics
- ___ Rehabilitation
- ___ Speech & Hearing
- ___ Special Clinics
- ___ Other _____

C. INFORMATION TO BE RELEASED TO AND USED BY OUSD

School/Department: _____ Contact person: OUSD School Nurse

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

D. PURPOSE OF THE REQUESTED INFORMATION

- Assist in determining most appropriate school education program/learning accommodations
- Assist in providing medical care during the school day
- School Enrollment
- Other: _____

E. TYPE/DESCRIPTION OF INFORMATION REQUESTED

- | | | |
|--|---|---|
| <input type="checkbox"/> Immunization Record | <input type="checkbox"/> Healthcare Provider's Report | <input type="checkbox"/> _____ Action Plan |
| <input type="checkbox"/> Physicians Orders | <input type="checkbox"/> Lab Results/X-ray Reports | <input type="checkbox"/> Appointment Dates/Times |
| <input type="checkbox"/> History and Physical/CHDP | <input type="checkbox"/> Mental Health Records | <input type="checkbox"/> Diabetes Management Plan |
| <input type="checkbox"/> Other: _____ | | |

F. SIGNATURE AUTHORIZING RELEASE OF INFORMATION

By signing below, I understand that the information released may include information regarding treatment, hospitalization, or outpatient care, including psychological/psychiatric impairment, drug abuse, alcoholism, AIDS, or HIV tests, and gives the requester permission to communicate with the health care provider, unless otherwise excluded here:

I also understand that the school district is responsible for maintaining confidential files for access and review only by involved educational staff. Academic, psychological, and health records are exchanged among California public schools.

I have read and understand the "Authorization Restrictions and Rights" on the backside of this form.

Unless revoked, this authorization will expire in 1 year, unless otherwise specified here:

APPROVAL: _____
Printed Name
Signature

Relationship to Patient/Student
Area Code and Phone Number
Date

AUTHORIZATION RESTRICTIONS AND RIGHTS

- ❖ Signing this authorization is voluntary. You can refuse to sign this authorization. Refusing to sign this authorization will not affect Oakland Unified School District's commitment to providing a quality education for your child. However, refusing to sign may inhibit the school's ability to implement an optimal plan of education, learning accommodations and/or health care plan for your child.
- ❖ This authorization may be changed at any time. To change this authorization, you must provide the organization or individual, listed in Section B of this form, with a written request to change the authorization. Any information disclosed before your written request to change the authorization is received may be used as previously permitted.
- ❖ You have the right to receive a copy of this document [Health Insurance Portability and Accountability Act (HIPAA)]. If you request it, you will receive a copy of this document after you sign it.
- ❖ Oakland Unified School District is responsible for maintaining confidential files for access and review by involving educational staff only. Academic, psychological, and health information are exchanged among California public schools. No further disclosure of this information by Oakland Unified School District should be done without specific written and informed release by a parent or legal guardian.
- ❖ If you authorize disclosure of information to a person that is not legally required to keep it confidential, the information may be re-disclosed and may no longer be protected by state or federal law.
- ❖ You may inspect or copy the information to be disclosed, as provided in CFR 164.524.

Documents adapted from the California School Nurses Organization generic form, 2004.